IMD Step-Down Consumer Satisfaction Survey:

Please take this opportunity to tell us how the services at the facility were effective in meeting your needs. We value any input that you give and we will take your feedback into consideration when making any plans to improve the quality and delivery of services.

The information that you provide will remain confidential and will not affect your services.

Name of Facility: _____

Your Length of Stay: _____

Please check the box that best describes your answer:

	Yes	Somewhat	No
1) Did you like your treatment groups?	[ ]	[ ]	[ ]
2) Were the groups helpful to you?	[ ]	[ ]	[ ]
3) Was your care plan discussed with you?	[ ]	[ ]	[ ]
4) Did you feel like your choices were considered in treatment and discharge planning?	[ ]	[ ]	[ ]
5) Did you feel that you learned to become self-sufficient in the community in preparation for discharge?	[ ]	[ ]	[ ]
6) During your stay, were you treated with respect?	[ ]	[ ]	[ ]
7) Were your issues addressed in a timely manner by facility staff?	[ ]	[ ]	[ ]
8) Overall, is this a place that you would recommend?	[ ]	[ ]	[ ]

Please indicate your overall level of satisfaction with your stay at the facility by circling a number below:

1	2	3	4	5	6	7	8	9	10
Not at all satisfied				Neither satisfied nor unsatisfied					Extremely satisfied